Save Your Sole Foot & Ankle Specialists

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Personal Information

Name: ____________________________ Birth date: ___________ Today's date: _______________
Address: ____________________________ City: ________________ State: ____ Zip: ___________
Home phone: __________________________ Cellular phone: _______________________________
Email address: ____
Ethnicity: African American / Asian American / Caucasian / Hispanic / Native American /
Pacific Islander (Hawaiian) / Other: ____
Preferred spoken language: ____
Age: ______ SS# last 4 digits: _________ Sex: _M / F_ Occupation: __________________________
Employer: ________________________________ Work phone: ______________________________
Preferred pharmacy: _________________________ Location: ________________________________
Primary family physician: ____
How did you hear of our clinic? ____
Marriage status (circle): Single Married Widowed Divorced Other
Emergency contact (list parent if minor):Name ____
Relationship: _______________________________ Phone number: ________________________

Today, my foot/ankle complaint is: 1. ____
(if time allows) 2. ____
The condition(s) has existed for (how long)?____
Is this related to a specific injury? ______________________ Date of injury? __________________
Have you had this problem before? _________ How long ago? ____________________________
Previous treatment(s)?____
Allergic to latex? ___Yes ___No What reactions do you get if "yes"?_____________________
Height:__________________ Weight:__________________ **Shoe Size**:______________________

Review of Systems: (check all that applies)
____ In general good health ____Recent significant weight gain ____Recent significant weight loss
Eyes: ___ Does not apply ___Wear glasses/contact lenses ____Cataracts ____Glaucoma ____Macular deg.
Ears/Nose/Mouth/Throat: ___Does not apply ____Sinusitis ____ Swollen lymph nodes
_____Difficulty hearing _____Using hearing aids __________________________Others (please describe)
Cardiovascular: ____Does not apply ___History of heart attack ___DVT ___High blood pressure
____History of stroke ____Heart murmurs _______________________________Others (please describe)
Gastrointestinal: ____Does not apply ___History of stomach ulcer ____IBS ___Heartburn/reflux
____ Hiatal hernia ____ Hepatitis (A/B/C) ____Cirrhosis _____________________Others (please describe)
Genitourinary: ____Does not apply ____Kidney stones ____Benign prostate hypertrophy (in men)
____ Overactive bladder ____ Frequent UTI ______________________________Others (please describe)

Please turn over →

Musculoskeletal: ____Does not apply ____Rheumatoid arthritis ____Psoriatic arthritis ____Osteoporosis
____Osteopenia ____Lower back pain/arthritis/herniated disc/pinch nerve
____Osteoarthritis(where? _______________) ____Sciatica_____________Others (describe)

Skin: ____ Does not apply ____Eczema ____History of Athlete's foot __________________Others (describe)

Neurological: ____Does not apply ____Migraine headache____Numbness of hands ____Seizures
_____Numbness of feet ____Multiple sclerosis ____ Charcot-Marie-Tooth disease

Psychiatric: _____Does not apply ____Depression ____Anxiety ____Bipolar disorder ____ADHD
____Others (describe)

Endocrine: ___Does not apply ____Gout ____Type 1 Diabetes ____Type 2 Diabetes
____Thyroid problems_____________Others(describe)

Hematologic: ___Does not apply ___Bleeding disorder ____ Anemia __________________Others(describe)

Allergic/Immunologic: ____Does not apply ___ Auto-immune disease ___ HIV positive

What operations or surgeries have you had? ____
____

___**Yes** ___**No** Do you smoke tobacco? If **yes**, how much? ____________ Smoking how long? __________
If **no**, did you smoke in the past? ______________________ When did you quit? ___________________

___**Yes** ___**No** Do you use recreational drugs? If **yes**, how much? ____________ Using how long? _______
If **no**, did you use in the past? ________________________ When did you quit? ___________________

___**Yes** ___**No** Do you drink alcohol? How much do you drink? ____________________________________

___**Yes** ___**No** Do you exercise on a regular basis? If yes, please describe. _______________________

Does anything significant run in your family? (i.e. heart disease, diabetes, foot deformities) Please list all conditions. ____
____

If there's anything else in your medical history that may be important for your physician to know in order to facilitate your treatment? Please describe: ____
____

RELEASE OF MEDICAL INFORMATION

I authorize Save Your Sole Foot and Ankle Specialists to release and obtain medical information as required for my treatment and processing of my insurance claim. I realize that it is my responsibility to pay for any services rendered. A monthly billing charge will be added to all accounts over sixty days. I understand if any balance is unpaid after 60 days, it will be sent to collections. I will also be responsible for the cost of collections, plus attorney and court fees, which may amount to 50% of the original owed amount.

I request that payment of authorized insurance or Medicare benefits be made on my behalf to Save Your Sole Foot and Ankle Specialists for the services rendered to me.

I authorize Save Your Sole Foot and Ankle Specialists to release any information needed to determine these benefits or the benefits payable for related services.

I authorize release of medical information to my primary care physician or other specialty physicians related to my treatment.

Signature:_________________________________ Date:________________________________